

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001136	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2015
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00181003.</p> <p>Complaint IN00181003 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: August 27, 2015</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Census bed type: Residential: 125 Total: 125</p> <p>Census payor type: Medicaid: 116 Other: 9 Total: 125</p> <p>Sample: 4</p> <p>Lake Park Residential Care Inc. was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00181003.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE